

**Dental Hygiene Committee of California**

2005 Evergreen Street, Suite 1050, Sacramento, California 95815

P 916.263.1978 F 916.263.2688 | www.dhcc.ca.gov/**REQUEST FOR CERTIFICATION OF LICENSE****\$25.00 FEE REQUIRED**
For each request**For Office Use Only:**

Cashiering No.: _____

Prepared by: _____

Date Mailed: _____

Please type or print clearly in ink. Be sure to provide all information.**VITAL INFORMATION**

Current Name: _____

Prior Last Name(s): _____

License Number _____ Social Security No. _____

Address of Record _____

City _____ State _____ Zip Code _____

Business Phone () _____ Residence Phone () _____

Address you wish the certification to be sent:**DECLARATION:** I authorize the Dental Hygiene Committee of California to send a certification of my California auxiliary license to the address above.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. This declaration is executed on the _____ day of _____ 20_____.

Signature _____

Please allow 30 days for your certification request to be processed.